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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10138

1. PLACE OF DEATH
a. COUNTY: Dorchester Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge, Maryland.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Yacht Basin

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cambridge, Md.
d. STREET ADDRESS: Edlon Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norman — Middle: Eldridge — Last: Adams Jr.

4. DATE OF DEATH: Month: ✱ 8 — Day: 18 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 4 1953

9. AGE (In years last birthday): 8 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Cambridge, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eldridge Adams

14. MOTHER'S MAIDEN NAME: Marjolyn Peters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give year or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. Eldridge Adams Edlon Park Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH: Instant
929.8
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
Fell into Yacht Basin while playing on pier.

20c. TIME OF INJURY — Hour: Ab 7 p.m. — Month, Day, Year: 8/18/61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Camb. Yacht Basin

20f. (City or town) Cambridge, (County) Dor. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): John Mace Jr. M.D.
DATE SIGNED: 8/22/61
Address (Street, city, town, or county): Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/20/1961
22c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park
22d. LOCATION (City, town, or country) (State): Cambridge, Maryland.

23. FUNERAL DIRECTOR — ADDRESS: Le Compte Funeral Service, Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: SEP 11 '61
24b. REGISTRAR'S SIGNATURE: Esther L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9065

CERTIFICATE OF DEATH

9959

M

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dor.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Cambridge

c. LENGTH OF STAY IN 1b: 3½ yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eastern Shore State Hospital

d. STREET ADDRESS: 28 Poplar St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print): First LAURA Middle THOMAS Last ANDREWS

4. DATE OF DEATH: Month Aug. Day 28 Year 1961

5. SEX: F

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/14/87

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William E. Thomas

14. MOTHER'S MAIDEN NAME: Mary Frances Todd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome due to cerebral arteriosclerosis, with psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 3 1958 to Aug 28 1961, that (I) (we) last saw the deceased alive on Aug 28 1961, and that death occurred at 12:20 M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Dredge M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-28-61

22c. PHYSICIAN'S NAME (Type): Thomas J. Dredge

22d. ADDRESS: E.S.S Hospital, Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: august 30

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Mem. Park

23d. LOCATION (City, town, or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth R. Thomas Jr. — ADDRESS: Cambridge

25a. REC'D BY REGISTRAR DATE: AUG 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9069 Item 14 Film C293 871761 mh 09060

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Cambridge
d. STREET ADDRESS: 115 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lois; Middle: Grace; Last: Ball

4. DATE OF DEATH: Month: August; Day: 12; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 23, 1913

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hollands Island

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Harrison

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: 217-28-3961

17. INFORMANT: Herbert L. Ball Sr. 115 Maryland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis: Arteriolar Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Endocarditis — 7 yrs.
DUE TO (c): Rheumatic CVD

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Thoracoplasty, Left & Lobectomy Left Lower Lobe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-14, 1957 to 8-12, 1961, that (I) (we) last saw the deceased alive on 8-11, 1961, and that death occured at 5:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. N. Baumann M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-12-61

22c. PHYSICIAN'S NAME (Type): W. N. Baumann, M.D.

22d. ADDRESS: 3 Church St. Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 14, 1961

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Mem. Park

23d. LOCATION (City, town or county) (State): Cambridge, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth R. Thomas

ADDRESS: Cambridge, Maryland

25a. REGISTRAR DATE: AUG 15 61

25b. REGISTRAR'S SIGNATURE: Emma S. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09061

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 219 Muir St

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 219 Muir St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
James	A.	Banks	August	15	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Negro		12/24/1886	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Oyster House	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sandy Cornish	Sarah Banks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	217-10-8491	Rosalie Cooper Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/16/61
EXAMINER'S NAME (Type): John Mace Jr.
Address (Street, city, town, or county): Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8/20/61	Old Field Cemetery	Cambridge, Dor. Md.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Herbert St.Clair	Cambridge, Md.	AUG 22 61	Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9071 **CERTIFICATE OF DEATH** Reg. Dist. No. 09062

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 12 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cambridge, Md. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Cambridge
d. STREET ADDRESS: 3 Robbins St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Collins Last: Banks

4. DATE OF DEATH: Month: Aug. Day: 8 Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 6, 1904

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Fertilizer MFG

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Mc. Daniel

14. MOTHER'S MAIDEN NAME: Nannie Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 220-01-0618

17. INFORMANT: Martha Banks Address: Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES M. HYPERTENSION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 AUG, 1961, to 8 AUG, 1961, that I last saw the deceased alive on 7 AUG, 1961, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. E. Guyby Jr. M.D. ADDRESS (Street, city or town, state): 105 CHURCH ST DATE SIGNED: 11 AUG 61

PHYSICIAN'S NAME (Type): W. E. GUYBY JR CAMBRIDGE MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/14/1961
22c. NAME OF CEMETERY OR CREMATORY: Trappe Cemetery
22d. LOCATION (City, town, or county) (State): Trappe, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert M. St. Clair Jr. ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: AUG 15 '61
24b. REGISTRAR'S SIGNATURE: Charles L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9072

CERTIFICATE OF DEATH

Reg. Dist. No. 19063

M

I

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Cambridge
c. LENGTH OF STAY IN 1b: 32 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chester Town RFD 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Preston — Last Boring

4. DATE OF DEATH: Month Aug — Day 30 — Year 1961

5. SEX: M

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 22 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ste. Engineer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Boring

14. MOTHER'S MAIDEN NAME: Matilda F Leagler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-05-9957

17. INFORMANT: Hospital Records — Address: Cambridge Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart
DUE TO
(b): Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: UNK

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 28, 1961, to Aug 30, 1961, that I last saw the deceased alive on Aug 29, 1961, and that death occurred at 9.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J. Dredge M.D. — ADDRESS (Street, city or town, state): E.S.S.Hospital, Cambridge, Md. — DATE SIGNED: 8-30-61

PHYSICIAN'S NAME (Type): Thomas J.Dredge, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: ~~Aug 30 61~~ Sept 1 1961

22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

22d. LOCATION (City, town, or county) (State): Greenmount Md

23. FUNERAL DIRECTOR'S SIGNATURE: J Hamilton Harrison — ADDRESS: St. Michaels Md

24a. REC'D BY REGISTRAR DATE: SEP 5 '61

24b. REGISTRAR'S SIGNATURE: Arthur E. Home

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9073

CERTIFICATE OF DEATH

1964

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Cambridge
c. LENGTH OF STAY IN 1b: 1 Mo-11 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gordon — Middle: Henry — Last: Bowen
4. DATE OF DEATH: Month: Aug — Day: 10 — Year: 1961
5. SEX: M
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 18 1912
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Mill
10b. KIND OF BUSINESS OR INDUSTRY: own self
11. BIRTHPLACE (State or foreign country): Maryland, Snow Hill
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Isaac Bowen
14. MOTHER'S MAIDEN NAME: Pearl Hales

15 WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no or unknown) Army (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: 218-24-2769
17. INFORMANT: Address: Hospital Records Cambridge Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cancer of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: Unk
157X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 1 1961, to Aug 10 1961, that (I) (We) last saw the deceased alive on Aug 9 1961, and that death occurred at 6:15 P.M., from the causes and on the date stated above

22a. SIGNATURE: Thomas J Dredge M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 8-10-61
22c PHYSICIAN'S NAME (Type): Thomas J. Dredge
22d. ADDRESS: E.S.S.Hospital, Cambridge, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 12 61
23c. NAME OF CEMETERY OR CREMATORY: Bates Methodist Cemetery
23d LOCATION (City, town, or county): Snow Hill (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Mary E. Dennis — ADDRESS: Snow Hill, Md
25c REC'D BY REGISTRAR DATE: AUG 14 '61
25b REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9074

CERTIFICATE OF DEATH

09065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

M

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rhodesdale - Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eldorado

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rhodesdale - Rural
d. STREET ADDRESS: Eldorado
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth; Middle: Wainwright; Last: Brinsfield

4. DATE OF DEATH: Month: August; Day: 12; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 10, 1900

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W. George Wainwright

14. MOTHER'S MAIDEN NAME: Jennie D. Brinsfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-10-9650

17. INFORMANT: Elwood H. Brinsfield, Rhodesdale, Md., R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of the Breast
DUE TO (b):
DUE TO (c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 7, 19 61, to Aug 12, 19 61, that (I) (we) last saw the deceased alive on Aug 12 19 61, and that death occurred at 8:28 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. Kingsbury M.D.
ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Seaford, Del.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 15, 1961
23c. NAME OF CEMETERY OR CREMATORY: Eldorado Cemetery
23d. LOCATION (City, town, or county) (State): Eldorado, Dorchester Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. J. Framptom and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9075 — 09066

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 25 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 134 East Appleby Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sina — Middle: Gertrude — Last: Burton

4. DATE OF DEATH: Month, Day, Year: August 25, 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 23, 1889

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country): Applegarth's, Dor.Co.,

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James E. Muark

14. MOTHER'S MAIDEN NAME: Julia Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: R.Julian Burton,E.Appleby Ave.,Cambridge,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): LYMPHO SARCOMA, GENERALIZED — INTERVAL BETWEEN ONSET AND DEATH: 3½ yrs

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 28, 19 58 to Aug 25, 1961, that (I) (we) last saw the deceased alive on Aug 24 1961, and that death occured at 6 AM, from the causes and on the date stated above.

22a. SIGNATURE: Alfred R. Maryanov M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/26/61

22c. PHYSICIAN'S NAME (Type): ALFRED R. MARYANOV

22d. ADDRESS: 136 RACE ST, CAMBRIDGE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 27,1961

23c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery

23d. LOCATION (City, town or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth R. Thomas

ADDRESS: Cambridge, Md.

25a. RECEIVED BY REGISTRAR DATE: AUG 29 61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9076

CERTIFICATE OF DEATH

09067

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Cambridge
c. LENGTH OF STAY IN 1b: 2 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eastern Shore State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DeLmar
d. STREET ADDRESS: 609 East
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Christopher Middle — Last COLLINS
4. DATE OF DEATH: Month Aug Day 6 Year 1961
5. SEX: M
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 8 1889
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: Engineer on R.R.
11. BIRTHPLACE (State or foreign country): USA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Josisha COLLINS
14. MOTHER'S MAIDEN NAME: MARY Elizabeth West
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO: 716-01-6970
17. INFORMANT Address: Hospital Records Cambridge Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4 General Arteriosclerosis
DUE TO: (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO: (c)
INTERVAL BETWEEN ONSET AND DEATH: UNK

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Aug 4 1961 to Aug 6 1961, that (I) (we) last saw the deceased alive on Aug 6 1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above

22a. SIGNATURE: Thomas J. Dredge M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: Aug 6 61
22c. PHYSICIAN'S NAME (Type): Thomas J. Dredge
22d. ADDRESS: E.S.S. Hospital, Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-9-61
23c. NAME OF CEMETERY OR CREMATORY: Fairview
23d. LOCATION (City, town, or county) (State): Delmar Del

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. S. Morrell Co - Delmar Del
25a. REC'D BY REGISTRAR DATE: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

2 1

FOR STATE HEALTH DEPT.

M

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Lives in [illegible] 09068

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
c. LENGTH OF STAY IN 1b: 1 yr 4mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Painter
d. STREET ADDRESS: Rm X-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FLOYD — Middle: — Last: COLLINS

4. DATE OF DEATH: Month: August — Day: 7, — Year: 19 61

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Colored	NEVER MARRIED ☒	March 10, 1939	22 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Laborer	Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James H. Collins	Olevia Upshur

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Address)
No -------	230-50-4131	James H. Collins, Williamsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable drowning — INTERVAL BETWEEN ONSET AND DEATH:

929.8

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☉

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Found floating

20c. TIME OF INJURY: Hour, Month, Day, Year	20d. INJURY OCCURRED: While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
[illegible] a.m. p.m. 8/7/ 1961		Tom to juice [illegible]	Williamsburg,	Dorchester,	Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE: Russell S Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

Address (Street, city, town, or county):

DATE SIGNED: 8/7/61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
Rem-Burial	8/10/1961	Painter Cemetery	Painter,	Virginia

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Herbert M. St.Clair,Jr., Cambridge, Md.	AUG 14 '61	Luther L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22 & 23 Film 9/12/61 mh

9078 Items 22 Film 9/12/61 jwk

CERTIFICATE OF DEATH

Reg. Dist. No. 09069

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 36Hrs. 3 fins.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cambridge, Md. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cambridge, Md.
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fredericka — Middle: Ann — Last: Collins

4. DATE OF DEATH: Month: Aug. — Day: 29 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug. 28-1961

9. AGE (In years last birthday): ___ yrs. — IF UNDER 1 YEAR: Months: / Days: — IF UNDER 24 HRS.: Hours: 36 Min.: 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Collins

14 MOTHER'S MAIDEN NAME: Carol A. Poset[illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mother-101 Academy St. Camb., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-25, 1961, to 8-29, 1961, that I last saw the deceased alive on 8-29, 1961, and that death occurred at 12 40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur N. Baumann M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 8-30-61

PHYSICIAN'S NAME (Type): Dr. Wilbur N. Baumann 3 Church St. Cambridge, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/30/61

22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

22d LOCATION (City, town, or county) (State): Cambridge, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Granville Le Compte — ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: SEP 5 '61

24b REGISTRAR'S SIGNATURE: [illegible] S. Hinds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9079

Reg. Dist. No. 09070

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Cambridge
d. STREET ADDRESS: 230 Pine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: Foster; Last: Cornish

4. DATE OF DEATH: Month: Aug. Day: 14, Year: 1961

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 21, 1916
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Canning
11. BIRTHPLACE (State or foreign country): Dorchester Co. Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Foster
14. MOTHER'S MAIDEN NAME: Evelyn Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---------
16. SOCIAL SECURITY NO.: 220-01-9789
17. INFORMANT: Address: Evelyn Foster, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive Cardiovascular Renal Disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 1 1961, to August 14, 1961, that I last saw the deceased alive on August 14, 1961, and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Edwin Fassett M.D. ADDRESS (Street, city or town, state): 227 Pine St., Cambridge, Md. DATE SIGNED: 8-17-61

PHYSICIAN'S NAME (Type): J. Edwin Fassett, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/18/1961
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): Cambridge, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert H. Pollard Jr.
ADDRESS: Cambridge, Md.
24a. REC'D BY REGISTRAR DATE: AUG 22 61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9080

CERTIFICATE OF DEATH

Reg. Dist. No. 09071

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fishing Creek, Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fishing Creek, Md.
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: — Last: Creighton

4. DATE OF DEATH: Month: 8 — Day: 7 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/10/1879

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seafood

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (State or foreign country): Fishing Creek, Maryland.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert F. Creighton

14. MOTHER'S MAIDEN NAME: Henrietta Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Mrs. Hansel Hall, Fishing Creek, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
DUE TO (b): Arteriosclerotic CVD — 7 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-23-56 to 8-2-61, that I last saw the deceased alive on 8-6-61, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. N. Baumann M.D.

ADDRESS (Street, city or town, state): 3 Church Street

DATE SIGNED:

PHYSICIAN'S NAME (Type): W. N. Baumann, M.D. — Cambridge, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/10/1961

22c. NAME OF CEMETERY OR CREMATORY: Hoosier Memorial Church Yard

22d LOCATION (City, town, or county) (State): Fishing Creek, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Le Compte Funeral Service, Cambridge, Md.

24a. FILED BY REGISTRAR DATE: AUG 15 61

24b. REGISTRAR'S SIGNATURE: Arthur S. Hinds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9081 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09072

FOR STATE HEALTH DEPT.

M

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1. PLACE OF DEATH
a. COUNTY: Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 60 years (MARYLAND)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 306 Henry Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 306 Henry Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Ralph; Last: Dodson

4. DATE OF DEATH: Month: August; Day: 16; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 28, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman self employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Somerset County

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Dodson

14. MOTHER'S MAIDEN NAME: Ida McClain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Raymond J. Dodson, 306 Henry St., Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Starvation
DUE TO
(b): Carcinoma stomach
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/17/61

EXAMINER'S NAME (Type): John Mace Jr.

Address (Street, city, town, or county): Cambridge, Md. (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 18, 1961

22c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery

22d. LOCATION (City, town, or country): Cambridge, Md.

23. FUNERAL DIRECTOR: Kenneth P. Hooper

ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

I

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9082 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09073

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 13
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Cambridge Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 23 Robbins St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grant — Middle: — Last: Ennalls

4. DATE OF DEATH: Month: Aug. — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/12/1910

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Food Canning

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grant Ennalls Sr.

14. MOTHER'S MAIDEN NAME: Amelia Travers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-12-569

17. INFORMANT: Address: Mrs. Christina E. Ennalls; Cambridge, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cononary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

SIGNATURE: John Mace Jr M.D. — DATE SIGNED: 8/10/61

EXAMINER'S NAME (Type): Dr. John Mace Jr. M.D.

Address (Street, city, town, or county): Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/13/61

22c. NAME OF CEMETERY OR CREMATORY: Crapo Cemetery

22d. LOCATION (City, town, or country) (State): Crapo, Dor. Md.

23. FUNERAL DIRECTOR: Herbert St.Clair — ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: AUG 22 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

TO PERSON IN CHARGE OF PREMISES: Page 2 should be used as a burial-transit permit. File page 1 with the State Board of Health. Page 3 should be delivered to the undertaker or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10147

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elliott
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: Md
b. COUNTY: Dor
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elliott
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Swain Middle Robert Lee Last Ewell

4. DATE OF DEATH: Month 8 Day 26 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/27/1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Solomon Ewell

14. MOTHER'S MAIDEN NAME: Mary N. Waller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Ebreson Moore, Address: Elliott

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
I 20.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): JOHN MACE JR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 8/27/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/28/61

22c. NAME OF CEMETERY OR CREMATORY: Family

22d. LOCATION (City, town, or country): Elliott (State): Md

23. FUNERAL DIRECTOR: Ruth S Kelloughby

ADDRESS: East New Market, Md

24a. REC'D BY REGISTRAR: AUG 28 1961

24b. REGISTRAR'S SIGNATURE: [signature]

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G295 9/18/61 iwk

Reg. Dist. No. 09074

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillsboro
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: - — Last: Fleming

4. DATE OF DEATH: Month: August — Day: 21 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-17-91

9. AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hackett Holt

14. MOTHER'S MAIDEN NAME: Ella DuPont Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: RECORDS - Eastern Shore State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

465X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture neck left humerus 8/2/61

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Slipped and fell in home

20c. TIME OF INJURY: Hour 9 AM p.m. — Month, Day, Year: 8/2/61 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Hillsboro, Caroline, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D

EXAMINER'S NAME (Type): John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 24, 1961

22c. NAME OF CEMETERY OR CREMATORY: Hillsboro Episcopal

22d. LOCATION (City, town, or county): Hillsboro (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Virgil Hobbs & Son — ADDRESS: Denton, Md.

24a. REC'D BY REGISTRAR DATE: AUG 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please explain in item 18. Give reason for delay in executing certificate, using the word "pending" in pencil in item 18. Give name and address of funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A1 MII
5M 2/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9085 — 09075

1. PLACE OF DEATH
a. COUNTY: Dorchester Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East New Market, Md.
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): None

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY: Lancaster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lancaster, Pa.
d. STREET ADDRESS: 618 S. Prince Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Webster — Middle: — Last: Friedel

4. DATE OF DEATH: Month: 8 — Day: 15 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 2 1886

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Shop

10b. KIND OF BUSINESS OR INDUSTRY: Black& Decker

11. BIRTHPLACE (State or foreign country): Felton Del

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Friedel

14. MOTHER'S MAIDEN NAME: Ella Wallheater

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Webster Friedel, 618 S. Prince St. — Address: Lancaster, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MED.CAL EXAM.NER ☒

EXAMINER'S NAME (Type): John Mace Jr.

Address (Street, city, town, or county)

DATE SIGNED: 8/16/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/18/1961

22c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn

22d. LOCATION (City town, or country): Lancaster, Pa. (State)

23. FUNERAL DIRECTOR: Le Compte Funeral Service, Cambridge, Md.

ADDRESS

24a. REC'D BY REGISTRAR: DATE AUG 18 '61

24b. REGISTRAR'S SIGNATURE: Arthur A. Hinkle

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09076

1. PLACE OF DEATH
a. COUNTY: Dor.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Airey
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Dor
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Airey
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Herbert; Middle: Linwood; Last: Harper

4. DATE OF DEATH: Month: 8; Day: 15; Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: 1/27/83

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Harper

14. MOTHER'S MAIDEN NAME: Elizabeth Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: —

17. INFORMANT (Name, Address): Herbert L. Harper Jr Airey Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 Mins.

DUE TO (b): —

DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. | Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): JOHN MACE JR.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

DATE SIGNED: 8/16/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/18/61

22c. NAME OF CEMETERY OR CREMATORY: East New Market

22d. LOCATION (City, town, or country): East New Market (State): Md.

23. FUNERAL DIRECTOR: Earl S. Willoughby ADDRESS: East New Market, Md.

24a. REC'D BY REGISTRAR DATE: AUG 22 '61

24b. REGISTRAR'S SIGNATURE: Clarence E. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9087

CERTIFICATE OF DEATH

09977

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Robert — Last: Medford
4. DATE OF DEATH: Month: August — Day: 29 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1879
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Dorchester County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert W. Medford
14. MOTHER'S MAIDEN NAME: Sarah Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Julia M. Medford, Williamsburg, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CORONARY ARTERY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: ½ HR.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROSIS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BENIGN PROSTATIC HYPERTROPHY
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from 10/10 1960 to 8/29 1961 that (I) (we) last saw the deceased alive on 8/29 1961 and that death occurred at 11 A.M., from the causes and on the date stated above

22a SIGNATURE: W. H. Hanks M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 8/30/61
22c. PHYSICIAN'S NAME (Type): W. H. HANKS
22d. ADDRESS: CAMBRIDGE Md.

23a BUR AL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Sept. 1, 1961
23c NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
23d LOCATION (City, town, or county) (State): Near Williamsburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.J.Framptom and Son, Federalsburg, Maryland
25a REC'D BY REGISTRAR DATE: SEP 5 '61
25b REGISTRAR'S SIGNATURE: Chelsea S. Krauss

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

14

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9088

Reg. Dist. No. 19073

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hospital
d STREET ADDRESS: 14X
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galt

3. NAME OF DECEASED (Type or print): First Joseph Middle W. Last Peacock

4. DATE OF DEATH: Month August Day 5 Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 10/20/72

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-lumberman

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service:

16. SOCIAL SECURITY NO: —

17. INFORMANT: Address: Records E.S.S. Hospital- Cambridge, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Fracture neck left femur — 22 days.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped and fell to floor.

20c. TIME OF INJURY: Hour 6:30 AM Month, Day, Year 7-11- 1961

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town) Cambridge (County) Dor. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/5/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/7/61

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

22d. LOCATION (City, town, or county): Smyrna (State) Del.

23. FUNERAL DIRECTOR'S SIGNATURE: G. Leslie Linnell ADDRESS: Middletown, Del.

24a REC'D BY REGISTRAR DATE: AUG 8 61

24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, stating the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Burial 8/7/11 Glenwood Cemetery Smyrna Del.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9089 — Reg. Dist. No. 09080

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIE Middle Last PEARSALL
4. DATE OF DEATH: Month AUGUST Day 18 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUG 24, 1871
9. AGE (In years on last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: MICHAEL H. SWING
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Myrtle Robertson — Address: Clayton, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b): Coronary Heart Disease — 5 yrs
DUE TO (c): Intertrochanteric Fracture left hip — 1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/17/61 19___ to 8/17/61 19___, that I last saw the deceased alive on 8/17/61, 19___, and that death occurred at 6:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lawrence Maryanov M.D.
ADDRESS (Street, city or town, state): 136 Race St. Cambridge, Md
DATE SIGNED:
PHYSICIAN'S NAME (Type): Lawrence Maryanov

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 21, 1961
22c. NAME OF CEMETERY OR CREMATORY: Denton
22d. LOCATION (City, town, or county) (State): Denton, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Virgil Brown Son Denton Md
ADDRESS:
24a. REC'D BY REGISTRAR DATE: AUG 21 '61
24b. REGISTRAR'S SIGNATURE: Cinthia L. Kinnard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

VS-A15-14
15M 6/55

TO ha[illegible] OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible] after death. Page 4 may be [illegible]ned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9090

Reg. Dist. No. 09461

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wingate, Maryland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester, Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Wingate
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lorena — Middle: Jones — Last: Reynolds

4. DATE OF DEATH: Month: 8 — Day: 7 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 27, 1884

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Jones

14. MOTHER'S MAIDEN NAME: Amanda Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Mr. Alfred Reynodls — Address: Wingate, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
331X
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma Bladder. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-12, 1961 to 8-5, 1961, that I last saw the deceased alive on 8-5, 1961, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D.

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): W. N. Baumann, M.D. — 3 Church St., Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/1961
22c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park
22d. LOCATION (City, town, or county) (State): Cambridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Le Compte Funeral Service, Cambridge, Md.
ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 16 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9091 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13482

1. PLACE OF DEATH
a. COUNTY: Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salem
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hgwy. U.S.50

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro Rt. #2
d. STREET ADDRESS: 21X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosie; Middle: Mae; Last: Shank

4. DATE OF DEATH: Month: August; Day: 7; Year: 1961

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 12/26/1898

9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months: 2; Days: 11 IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): Boonsboro Rt. #2

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HARRY E. SMITH

14. MOTHER'S MAIDEN NAME: Fannie Arnold Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Hazel Smith Address: Boonsboro Md. Rt.#2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intracranial injury — Interval between onset and death: Instant

DUE TO (b): Multiple fractures skull — Interval between onset and death: Instant

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Passenger in auto, in collision with another auto.

20c. TIME OF INJURY: Hour a.m. p.m.: ; Month, Day, Year: 8/7/61 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 50 Near

20f. (City or town): Salem, (County): Dor. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: John Mace M.D.

EXAMINER'S NAME (Type): Dr. John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/8/61

Address (Street, city, town, or county): Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/10/61

22c. NAME OF CEMETERY OR CREMATORY: Mt. Lena Cemeterey

22d. LOCATION (City, town, or country): Boonsboro (State): Md.

23. FUNERAL DIRECTOR: Kenneth R. Thomas Jr.

ADDRESS:

24a. REC'D BY REGISTRAR DATE: AUG 14 1961

24b. REGISTRAR'S SIGNATURE: Curtis L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09083

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harrison Ferry Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
d. STREET ADDRESS: Harrison Ferry Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ross — Middle: — Last: Spears

4. DATE OF DEATH: Month: August — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1904

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Day Laborer at Pickle Plant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tennessee (Hawkins Co.)

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Spears

14. MOTHER'S MAIDEN NAME: Eliza Waterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Elizabeth Wheeler, Abingdon, Virginia
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
420
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: John Mace Jr. M.D.

EXAMINER'S NAME (Type): John Mace, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: Aug. 9, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 13, 1961

22c. NAME OF CEMETERY OR CREMATORY: High Point Cemetery

22d. LOCATION (City, town, or country) (State): Abingdon, Virginia

23. FUNERAL DIRECTOR — ADDRESS: J. J. Framptom and Son, Federalsburg, Maryland

24a. REC'D BY REGISTRAR — DATE: AUG 11 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 19184

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN Tb: 7yr 9mo 26days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galestown
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Houston — Middle: Wesley — Last: Wheatley
4. DATE OF DEATH: Month: August — Day: 23 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 12-18-1885
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm laborer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Wheatley
14. MOTHER'S MAIDEN NAME: Mary Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: RECORDS: Eastern Shore State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Fracture neck r. femur — 2 mo.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile brain disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [X] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped and fell on ward of hospital.
20c. TIME OF INJURY: Hour: 7.25 A.M. — Month, Day, Year: 6-30-61 19
20d. INJURY OCCURRED: White at work [ ] Not white at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town): Cambridge — (County): Dor. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Mace Jr.
EXAMINER'S NAME (Type): John Mace Jr.
M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 8/24/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-26-61
22c. NAME OF CEMETERY OR CREMATORY: EAST NEW MARKET
22d. LOCATION (City, town, or county): EAST NEW MARKET. (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Smith Funeral Home, Sharptown, Md.
ADDRESS
24a. REC'D BY REGISTRAR DATE: AUG 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09085

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Vienna
c. LENGTH OF STAY IN 1b: Few Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Vienna
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jonnie — Middle: L. — Last: Wilson

4. DATE OF DEATH: Month: Aug. — Day: 2 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 5, 1915

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Wilson

14. MOTHER'S MAIDEN NAME: Annie Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 425-34-2713

17. INFORMANT — Address: Annie C. Wilson, Winona, Miss.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Gunshot wounds abdomen — Few mins.

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Was shot 5 times by another man.

20c. TIME OF INJURY — Hour a.m. p.m. / Month, Day, Year: 12:10 p.m. 8/5/61 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Dorco Labor Camp Nr. Vienna, Dor. Md.

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): Dr. John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/10/61

Address (Street, city, town, or county) (State): Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Rem-Burial

22b. DATE THEREOF: 8/10/1961

22c. NAME OF CEMETERY OR CREMATORY: Winona Cemetery

22d. LOCATION (City, town, or country) (State): Winona, Mississippi

23. FUNERAL DIRECTOR — ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur E. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9095

19086

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linkwood
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linkwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VAN — Middle: Byren — Last: Wright

4. DATE OF DEATH: Month: Aug — Day: 3 — Year: 1961

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 23, 1895

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wright

14. MOTHER'S MAIDEN NAME: ~~[illegible]~~ Frances Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Alberta Wright — Address: Linkwood, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Arteriosclerotic Cardiovascular disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from July 20, 1961, to Aug 3, 1961, that (I) (we) last saw the deceased alive on Aug 2 1961, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. Edwin Fassett — 22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-7-61 — 23c. NAME OF CEMETERY OR CREMATORY: Elzey's Cem — 23d. LOCATION (City, town, or county) (State): Jesterville, md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Easton, md.

25a. REC'D BY REGISTRAR DATE AUG 9 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59